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Reduction of illicit demand for drugs: world situation with regard to drug abuse

World situation with regard to drug abuse

Note by the Secretariat

Summary

The present report is based on data received from the 112 countries that submitted the annual reports questionnaire for 1998, supplemented by additional information. Thirty-one countries in Africa, Asia, the Americas and Europe reported increased abuse of heroin. In the United States of America, heroin abuse appears to have been slowly rising since 1992. In both Europe and the United States, higher levels of abuse have been accompanied by an increase in the use of non-injecting modes of administration (smoking in Europe, snorting in the United States). Thirty countries reported the growing abuse of amphetamine-type stimulants. A source of considerable concern is the rising trend in the abuse of methamphetamine in south-east Asia in general, and in Thailand in particular. Increasing abuse of amphetamine is also reported in many countries of the European Union. The number of countries reporting the existence of injecting drug users (IDUs) and infections with the human immunodeficiency virus (HIV) among IDUs continues to grow. Developing countries have become highly vulnerable to drug abuse, which puts a heavy burden on their already fragile health and social infrastructures. In many countries (for example, in the Russian Federation and adjacent countries, and in central and eastern Europe and various Asian countries), there has been, or there is a potential for, an outbreak of epidemic infections of HIV among IDUs. Hepatitis C infections among IDUs and drug-related mortality (mainly involving a drug overdose) are also causing concern in some countries. While data collection systems have improved in some parts of the world, there remains a critical need for improvements designed to ensure a full understanding of the patterns and scale of, and the trends in, the global problem of drug abuse. To facilitate that task, it would be useful to develop standardized indicators and conduct capacity-building exercises in developing countries.

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I. Introduction

1. The present paper on recent trends in and patterns of illicit drug consumption provides an opportunity to reflect on the critical global issues relating to demand for drugs at the dawn of a new century. It is structured around the key topics that emerged from a review of the situation with regard to drug abuse at the national, regional and global levels.

2. The analysis is based on data provided by countries that have, in compliance with their obligations under the international drug control treaties, completed and sent in the annual reports questionnaire. For 1998, 112 countries completed the annual reports questionnaire and returned it to UNDCP. That represents a marked improvement in the number of submissions over previous years (80 and 83 in 1996 and 1997, respectively). However, as the data presented below illustrates, detailed information on drug abuse is often missing. It is interesting to note that about half of the countries that completed the sections of the annual reports questionnaire on demand reduction were unable to comment on whether demand for the most commonly abused drugs currently showed an increasing, decreasing or stable trend.

3. Not all of the missing data in the part of the annual reports questionnaire on drug abuse can be simply attributed to the lack of available information for countries to report. Shortcomings in the reporting requirements under the section on drug abuse itself can lead to problems with both data collection and analysis. For example, the Ecstasy group of drugs is inadequately covered. Other problems arise because the variables used in the annual reports questionnaire do not always reflect the wider current practice. Therefore, even when countries have data on a topic area, it can still be difficult to provide the information in the required format. The Commission on Narcotic Drugs may accordingly wish to initiate the revision of the annual reports questionnaire.

4. To ensure that the present report provides a sound review of the current situation with regard to drug abuse, data from the annual reports questionnaire are supplemented with other appropriate information, in line with the agreement of the Commission, as set forth in the report on its fortieth session.[1]

II. World situation with regard to emerging trends in drug abuse

5. Countries are requested to provide simple reports on trends in their annual reports questionnaire. The information provided for amphetamine-type stimulants, cocaine, cannabis and heroin is summarized in figure I and reported in detail in tables 1-4 contained in the annex to the present report.

A. Heroin

6. In the annual reports questionnaire, 31 countries (64 per cent of those responding) reported that heroin abuse had increased during 1998. An additional seven countries (15 per cent) reported no change, and 10 (21 per cent) that abuse had decreased during the reporting period. Six African countries reported increases in heroin abuse, supporting other evidence that heroin abuse is becoming more established on the continent. The South African Community Epidemiology Network on Drug Use[2] reported that requests for heroin treatment increased in 1998, and that there was a fall in the average age of those treated. However, in terms of overall demand, heroin abusers represented only 5 to 6 per cent of all specialist drug treatment requests in Cape Town and Gauteng. Most heroin abusers were smoking the drug. However, sporadic reports of drug-injecting were also received. Heroin abuse has also been reported in Ghana, Kenya, the Libyan Arab Jamahiriya, Mauritius, Morocco, Nigeria, the United Republic of Tanzania and Zimbabwe. While heroin abuse may be increasing in some areas in Africa, relative prevalence rates in general still appear very low, and large geographical variations are evident. However, increasing industrialization, political problems, the impact of trafficking routes, population movements and tourism all suggest a potential for future increases. The question whether increased injecting is likely in Africa also exists, but as cultural resistance to that mode of administration appears common in many countries, the potential for any dramatic increase remains unclear.[3]

7. Some developed countries that have had previous experience with problems of heroin abuse have expressed concern that consumption might once again be increasing. Most notably, reports from the United States of America and, to some extent, the United Kingdom of Great Britain and Northern Ireland support that possibility. In the United States, heroin abuse has been increasing since 1992. The

estimated number of heroin abusers recorded in the month prior to the survey date increased from 68,000 (less than 0.1 per cent of the population) in 1993, to 325,000 (0.2 per cent of the population) in 1997.[4] In the United States, the Community Epidemiology Work Group[5] reported that during the period 1997-1998, indicators for heroin abuse continued to show an increase in 12 cities covered by the Work Group. In some areas, indicators had shown an upward trend for more than three years. Miami reported the sharpest increase during that period (63 per cent). Elsewhere, the picture is less clear. In seven other sites covered by the Work Group, abuse remained relatively stable in 1998, but increases had occurred in most of them during the previous reporting period.

8. The increase in heroin purity available in the United States has been linked with an increase in heroin-snorting, often among younger abusers. Heroin abusers admitted to treatment in Newark, New Jersey, and New York City in 1998 were more likely to report snorting than injection. While heroin-snorting does not carry the same dangers of infection as injecting use, fears do exist that the greater social acceptability of that mode of administration may make the drug more attractive to a wider group of young people. Concerns also exist that chronic heroin abusers will be, in the longer term, drawn to injecting as a more efficient mode of administration.

9. Overall, the position of heroin abuse in Europe appears relatively stable. However, the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) has drawn attention to reports of increased heroin abuse in several European countries in 1998.[6] The increases mostly concern heroin-smoking and indicate that the practice is spreading from urban to more rural locations. It has also been noted that because of structural lags in most indicators (treatment attendance registers have an in-built lag of usually several years between an individual's first use and the first request for treatment), current information sets may, in the short term, poorly reflect new trends in heroin abuse.

10. Reports from central and eastern Europe also suggest that heroin-smoking is becoming more popular. Data from the Council of Europe study on first requests for treatment, which covers 23 European cities, including a number of cities in central and eastern Europe, note that "the classic picture of the injecting drug user is vanishing and smoking heroin ... plays a significant role all over Europe".[7] In seven cities in the network, the proportion of non-injecting heroin users increased between 1996 and 1997. Figure II illustrates that trend for Warsaw. Opiate abusers in Poland have traditionally used poppy straw to produce a locally made opiate drug (known as "Polish heroin"). However, since 1995, the number of requests for treatment by people abusing imported heroin has increased. The vast majority are smoking the drug. In 1998, for the first time, a majority of those seeking first treatment were heroin smokers.

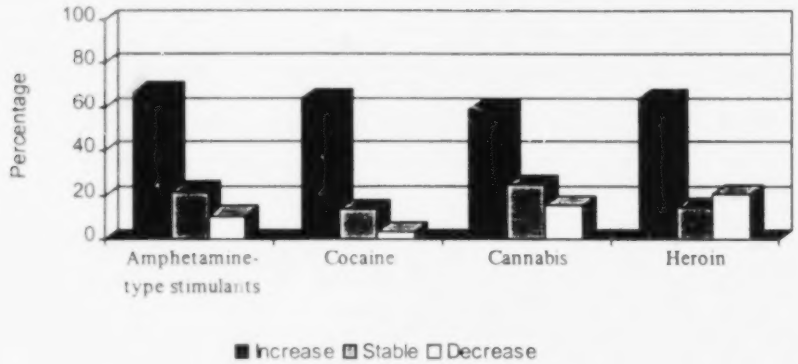
11. Eleven countries in Asia also reported increased heroin abuse in 1998 (annex table 1). Heroin abuse, by either smoking or injecting, now characterizes the chronic drug-abusing population in many south and east Asian countries. In some countries, heroin abuse appears to be replacing the abuse of opium (for example, in Hanoi).[8] Elsewhere, abuse is associated with polydrug patterns of consumption. Heroin abusers may also commonly consume pethidine, dihydroethorphine and morphine (China), and buprenorphine (Bangladesh, India and Pakistan).[9]

B. Abuse of amphetamine and methamphetamine

12. Thirty countries have reported increases in the abuse of amphetamine-type stimulants during 1998. The term "amphetamine-type stimulants" is used with little precision, and the annual reports questionnaire does not currently give adequate coverage to drugs of that type. The term is used in the present context as a convenient shorthand for a range of drugs, the most notable being amphetamine, methamphetamine and the Ecstasy group of substances. Data on increases in abuse of amphetamine-type stimulants in 1998 can be found in annex table 2.

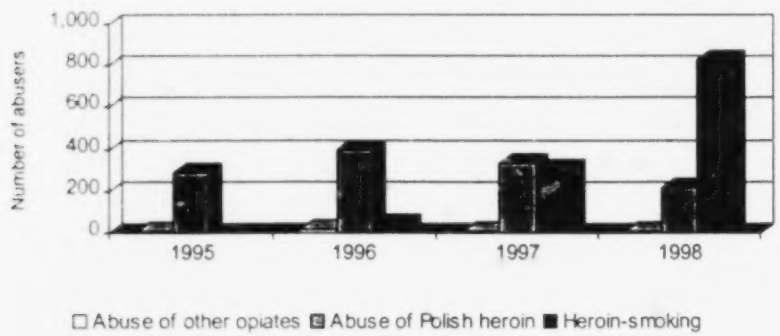
13. Data from the European Union suggest that amphetamines remain the second most-popular drug (in terms of lifetime prevalence) after cannabis. The dominant trend is a continuing rise in availability and abuse. Most abuse is by young people in the context of some form of youth culture. In some countries (mostly northern European), smaller populations of chronic abusers (often drug injectors) exist. Ecstasy (methylenedioxymethamphetamine and analogues) still appears to be popular, but increases in abuse are not as evident as earlier in the decade, and in some countries abuse may have stabilized, or may even be in decline. That does not necessarily imply that Ecstasy abusers have stopped taking stimulants.

Figure I
Trends in drug abuse, 1998



Source: Annual reports questionnaire

Figure II
First requests for treatment for drug abuse, Warsaw, 1995-1998



Source: J. Sieroslawski, Ograniczenie Ulywania Sybstanciji Psychoktywnych "Substance uses and related health problems", *Alkoholizm i Narkomania* vol. 2, No. 35 (1999).

Rather, it may be that some have switched to alternative drugs (amphetamines or cocaine).

14. With a few exceptions, amphetamine and methamphetamine abusers do not show up for treatment in any great numbers. In the 23 cities covered in the European multi-city data set for 1997,[7] only one, Prague, reported a predominance of methamphetamine abusers (around 50 per cent of all first requests for treatment). The only other significant reports of problems came from Warsaw (about 15 per cent of first requests for treatment). In the United States the study "Monitoring the future" (1997-1998) reports a decline among tenth-graders in the United States. Abuse of stimulants had declined for two years among eighth-graders, and levelled off among twelfth-graders. Prevalence during the year prior to the survey was between 7 and 11 per cent for those groups. In wider population groups, indicators on methamphetamine were mixed, suggesting a fairly stable situation. The picture was less clear for the Ecstasy group, and recent data have suggested a moderate increase in Ecstasy abuse in the United States.[9]

15. Australian data do not provide a clear picture, with some indicators suggesting that amphetamine abuse may be stable, or even in decline, while recent school survey data suggest some increase among youth. Again the suggestion has been made that this may be due in part to the more widespread popularity of cocaine.[10]

16. Methamphetamine problems have been evident in some countries in south-east Asia for many years. However, in recent years, a dramatic increase in the abuse of the substance in the region has refocused attention on the problem, and considerable public concern is currently being expressed regarding the abuse of the drug. Historically, methamphetamine abuse has been an identified problem since the Second World War in Japan, since the 1970s in the Republic of Korea and since the mid-1980s in the Phillippines and Taiwan Province of China. In recent years, the problem appears to be spreading more widely across the region, and prevalence also appears to be rising in countries that have a longer experience with the drug. In Malaysia, there is evidence of increasing abuse of methamphetamine. In the Philippines, methamphetamine, known locally as "shabu", is the primary drug of abuse. Prevalence is also rising in Singapore, and some data exist to suggest that the problem is increasing in Brunei Darussalam and Viet Nam.

17. In Thailand, in particular, increasing prevalence of methamphetamine abuse has been observed. The office of the Narcotics Control Board estimates a fourfold increase in overall abuse during 1998.[11] In simple terms, two patterns of abuse are visible. The drug is abused by members of particular occupational groups (transport workers, sex workers, seafarers and construction workers), primarily to increase the capacity for prolonged economic activity. Such instrumental abuse of stimulants has been established for some time in Thailand, and particular concern has previously been expressed about the abuse of amphetamine-type stimulants by long-distance drivers. On the other hand, methamphetamine is increasingly being abused by students and young people in general. School samples show a small increase in prevalence from 1.16 per cent in 1996 to 1.4 per cent in 1999. However, that may not represent a particularly sensitive indicator of methamphetamine abuse among young people in the country. Geographical variations in patterns of abuse also exist, with problems tending to be more serious in the northern part of the country, where much of the methamphetamine is imported. The increasing popularity of the drug among young people is reflected in the alarming number of cases of those under 18 appearing before family courts for methamphetamine possession, which rose from 119 in 1995, to 7,726 in 1998.

C. Cocaine

18. Thirty-four countries reported an increase in the annual reports questionnaire for 1998 (annex table 3). Cocaine was reported by an estimated 1.5 million people in the United States in 1997 (0.7 per cent of the population aged over 12), significantly less than the peak of 5.7 million (3 per cent) in 1985. Currently, the picture is not particularly clear. In 1999, the Community Epidemiology Work Group reported that cocaine/crack indicators increased in 10 cities, were stable in 8, and decreased in 2. The increases in 10 cities were surprising, given the fact that cocaine indicators had been relatively stable in those cities during the past several years. In Australia and Europe, some evidence exists to suggest that cocaine is gaining in popularity.

19. In the European Union, although some indicators suggest a steady increase in the cocaine market, distinct geographical variations can be observed. Cocaine appears most available in larger cities and in those areas with a relatively large number of abusers of other drugs, for example, London and Amsterdam. Recent national survey data from the United Kingdom[12] suggest that abuse of

cocaine among those aged 16 to 29 increased from 1 per cent in 1994 to 3 per cent in 1998. Increases in cocaine abuse were disproportionally observable in London and some other large cities in the United Kingdom, where prevalence rates had risen considerably. Amsterdam appears to be the only city in Europe to report significant requests for treatment for cocaine problems. In 1997, 37.5 per cent of first treatment requests in Amsterdam were for a cocaine problem.[7] However, such data are reported on the basis of outpatient admissions only, and that may result in difficulties in comparing data from Amsterdam with that from other cities.

D. Cannabis

20. Thirty-eight countries report increased cannabis abuse in the annual reports questionnaire (annex table 4). Most geographical regions were affected, and the observation that cannabis is the most widely abused illicit substance can be applied to an increasing number of countries. Prevalence rates for cannabis are often far higher than for other drugs. In addition, the number of people who admit using cannabis regularly is often far higher. Globally, estimates of annual prevalence vary, but are generally high in the following countries and regions: west Africa (for example, Ghana, Nigeria, Sierra Leone); Oceania (Australia, the Federated States of Micronesia, New Zealand and Papua New Guinea); Central America and the Caribbean (notably Jamaica); North America (Canada and the United States); and a number of European countries. Annual prevalence rates (use in the last year) are often very high. For example, recent estimates for the annual prevalence of cannabis abuse among those aged over 15 were 16 per cent for Sierra Leone, 15 per cent for Micronesia, 14 per cent for Ghana and 18 per cent for Australia.

21. In some regions, cannabis abuse appears to be increasingly similar from country to country. For example, not only have most countries in the European Union experienced an increase in cannabis prevalence during the 1990s, but patterns of abuse also appear to be converging. Differences may still exist in terms of cannabis abuse in the general population (between 10 and 30 per cent of lifetime prevalence), but differences are far less marked when youth populations are compared.

III. Prevalence of drug abuse among youth: globalization of youth culture and drug abuse

22. Developments in communications and information technology are leading to a harmonization of youth culture across Europe, and to some extent globally. Young people increasingly have access to the same youth culture in terms of clothing, music and fashion. It can be argued that illicit drugs, or at least some patterns of illicit drug abuse, act in many respects like other commodities in an increasingly global market. For example, the spread of Ecstasy abuse indicates that the young and affluent in many parts of the world increasingly have access to the same cultural options. That is reflected in Ecstasy abuse, together with its associated cultural accompaniments of musical styles and dance events, which have spread rapidly and extensively in little more than a decade. In the late 1980s, such behaviour went largely unrecognized in the few western cities where it developed. Today, reports of Ecstasy abuse in similar settings can be found in many countries around the world. Ecstasy abuse has been reported among the well-educated in Thailand, among the young and affluent in the Russian Federation, and in dance and "rave" parties in South Africa. In relative terms, the numbers of individuals involved may be small, and compared to other drug problems, the impact of such drug abuse is often not profound. However, it does illustrate a disturbing trend when drug abuse patterns quickly transcend national boundaries and global patterns become established. The challenge is also to develop a global strategy, using the youth culture, to counter drug abuse among youth.

IV. Drug injection and blood-borne infections

A. Human immunodeficiency virus

23. In global terms, drug injection, through the health problems associated with the practice, remains the biggest cause of morbidity and mortality resulting from the abuse of illicit drugs. In annex table 5, a list of the 136 countries that have reported the existence of populations of injecting drug users (IDUs) can be found. In addition, 93 countries (68 per cent) also reported that infection with the human immunodeficiency virus (HIV) has been identified among

drug injectors. The list has grown since it was last presented to the Commission in 1997, when 122 countries reported IDU populations. The number of countries[13] reporting injecting populations has grown consistently throughout the 1990s; in 1992, only 80 countries reported the existence of IDUs. Although the number of countries identified as having an IDU population represents nearly three quarters of the total number of countries in the world, the list is still probably an underestimate of the real number. That is true in terms of both the existence of injecting populations and the number of countries reporting HIV infection within that group. It should be noted that the prevalence rates for drug-injecting varies greatly, but is usually low. For many countries that report the existence of drug-injecting, the actual numbers of current IDUs will therefore be small. However, as drug injection is not a randomly distributed behaviour, high prevalence may be found within certain subpopulation groups or geographical areas.

24. The increase in reports of new drug-injecting populations illustrates a trend, apparent in recent years, towards the spread of injecting to an increasing number of developing countries where previously the practice was often virtually unknown. A number of reasons have been suggested for the spread of injecting;[14] including the following: a technical, or practical, advantage over other modes of administration (it is easier to use and to conceal injecting equipment); an economic advantage (dosage level established more efficiently); and the development of new communication links and population movements that allow greater transfer of practices between populations, and that therefore facilitate diffusion. In addition, changes in the trafficking and the production of illicit drugs indirectly influence local consumption patterns (as reflected in heroin production moving closer to drug cultivation areas in south-east Asia, or trafficking routes in west Africa and central Europe leading to an increase in local heroin abuse).

25. An obvious concern of increased injection relates to blood-borne infections in general, and HIV infections in particula.. Extrapolations from case data on acquired immune deficiency syndrome (AIDS)[15] suggest that the cumulative number of HIV infections among IDUs could be around 3.3 million (up to 1997). Such estimates should be treated with caution, since both the true size of the global IDU population (estimated at 5 million[14] in 1992) remains unknown, as does the rate of HIV infection among IDUs. What is clear however, is that both drug injection and HIV infection can, under certain conditions, rapidly spread within and between populations. That is a particular concern for developing countries, where knowledge about the risks of sharing injecting equipment may be poor or even lacking, and sterile injecting equipment may be scarce. In those circumstances, explosive epidemics have been documented, where the introduction of injecting has been accompanied by a dramatic and rapid escalation in HIV infection rates.[16]

26. Injecting drug abuse is the main, or a major, mode of transmission for HIV infection in the following regions: east Asia and the Pacific, Central Asia and eastern Europe, the Middle East and north Africa, Latin America, North America and western Europe.[17] Drug-injecting may also contribute to increased incidence of HIV infection in the general population through the transmission of infection to the children of drug-injecting mothers (perinatal transmission), and through sexual contact between drug injectors and non-injectors. Numerous studies have found drug injectors to be disproportionally likely to be involved in the sex industry or to engage in high-risk sexual activities.

27. A distinction can be made between developed countries that often have long-established populations of IDUs, and developing countries where injecting is often a relatively new phenomenon. In the former, for the most part, the rate of new infections remains relatively low. Where prevalence rates are still increasing, the increases observed are not dramatic, as compared to the rapid escalations in prevalence observed earlier in the epidemic. Nevertheless, drug-injecting remains a major risk factor for new HIV infections in many developed countries, and actual prevalence rates vary greatly. In developing countries where recent epidemics have occurred, or are currently occurring, the potential for future rapid escalation in prevalence appears pronounced, even if current infection rates may be minimal. The scale of the problem, or the potential problem, also appears far greater. For large developing countries, even if drug injection rates remain relatively low, the number of individuals who may be affected, in numerical terms, is considerable.

28. In the European Union, considerable variation is observed between countries in respect to rates of HIV infection, with marked differences between the relatively high rates reported in Spain (32 per cent), France (15.5-18.3 per cent), Italy (15.7 per cent) and Portugal (14 per cent), and the lower rates found in countries like Ireland (0.9 per cent), United Kingdom (1 per cent), Austria (1.5-2 per cent) and Sweden (2.6 per cent). It should be noted

that within countries, considerable geographical variation in prevalence rates exists, and therefore national rates should be interpreted with caution. With respect to trends, the overall situation in the European Union appears to be relatively stable. In some countries (France and Italy) rates appear to be declining, while elsewhere the opposite may be true. In particular, concern exists that in Portugal, the prevalence of HIV infection among drug injectors may be rising. However, for the region as a whole, EMCDDA studies suggest that, for most countries, the highest incidence occurred between 1986 and 1988.

29. In the United States, drug injection remains the second most common mode for the transmission among AIDS patients.[18] In June 1997, injection-related AIDS cases accounted for 32 per cent of all new diagnoses. It is estimated that in the 96 largest cities, there are 1.5 million drug injectors, of whom 14 per cent are likely to be infected with HIV. However, incidence rates do not suggest explosive growth in drug-related HIV rates, as was observed in some cities earlier in the epidemic, or as is currently observed in some developing countries. It should also be noted that crack cocaine smokers are also found to have elevated rates of HIV infection in North American studies. Studies have associated both injecting drug use and crack cocaine use with elevated levels of high-risk sexual behaviours. In 1996, in Canada, approximately half of the estimated HIV infections that have been detected were attributed to drug injection.[19] Data from testing programmes suggest that injecting drug abuse is becoming an increasing risk factor for new HIV infections. Although HIV prevalence rates across Canada appear to vary considerably, there has in general been an increase during the 1990s. For example, prevalence was estimated among IDUs in Montreal at 5 per cent in 1988 and 19.5 per cent in 1997. Similar increases have been observed in Vancouver, British Columbia.

30. In Australia, most new HIV infections occur through sexual contact between men.[13] Over 85 per cent of all HIV transmission[13] are attributed to such behaviour. There is no evidence to suggest that the very low rates of transmission associated with drug injection are changing, and prevalence rates appear stable among sample groups of IDUs attending needle exchange programmes.

31. HIV infections remain a serious problem in the countries discussed above. However, explosive escalations in infection are not currently happening, and there are grounds for cautious optimism that in many developed countries interventions and measures put in place to limit the potential for increased infection among IDUs have been at least partially successful. In addition, investments in improved surveillance of drug injectors have also paid dividends, and a far sounder knowledge base now exists to allow informed debate on the current situation.

32. For 1999, the steepest HIV curve in the world was recorded in States of the Commonwealth of Independent States, where the proportion of the population infected doubled between the end of 1997 and the end of 1999.[17] If the remainder of central and eastern Europe is included, the Joint United Nations Programme on Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome and the World Health Organization estimate that the number of infected individuals rose by a third during 1999. That number is currently estimated at 360,000. In the Russian Federation, approximately half of all cases of HIV infection were reported during the first nine months of 1999. Drug-injecting is considered the primary factor for infection in the region. Because of some of the preparation methods used in the area, the drug solutions themselves may also pose a risk of HIV infection, regardless of injecting practice. HIV infection is increasing dramatically in Moscow, where 2,700 new cases were reported in 1999 (three times as many as in all previous years combined). Those rates appear even higher in the towns and cities around Moscow. Both drug-injecting and HIV infection appear to have spread across many parts of the Russian Federation. For example in Irkutsk, nearly 13,000 infections have been reported.

33. The HIV epidemic in the region appears to have started first in the Ukraine, about 1994 or 1995, and the country is now seeing a subsequent increase in AIDS cases. In the Russian Federation, the epidemic followed somewhat later (1995-1996). In some Russian cities (Kaliningrad, Odessa and Svetlogorsk), the incidence of HIV infections appears to have fallen recently, which is probably an indication of saturation levels of infection among the local populations of IDUs.[20] In 1997 and 1998, the first cases of HIV among IDUs began to be detected in the Baltic States, the central Asian States and the Caucasus region. While the absolute number of HIV cases remains low, IDUs are increasingly accounting for the majority of new infections. By the beginning of 1999, Estonia and Turkmenistan were the only newly independent States to have emerged from the former Soviet Union in which no HIV infection among IDUs had been reported.

34. The understanding of the potential for increased injecting and for increased HIV prevalence is handicapped

by the absence of good data sources in the region. In particular, the actual levels of drug injection in the region appear to vary greatly, and it cannot be assumed that all areas have significant injecting populations. Nevertheless, sufficient evidence does exist to suggest that HIV infection among IDUs in the region represents a most serious threat.

35. To date, the countries of central and eastern Europe, with the exception of Poland, have not experienced significant HIV infection among IDUs. In Slovakia, Hungary, Slovenia, the Czech Republic and Croatia, only small numbers (2, 6, 12, 17 and 30, respectively)[20] of HIV-positive injectors had been identified by the end of 1998. However, there is some evidence to suggest that in those countries, the potential for an increase in infection rates exists. For example, among new treatment attenders in Prague (Czech Republic), 48 per cent had shared injecting equipment in the month prior to entering treatment. In Bratislava, that figure was 37 per cent.[7] How long HIV among IDUs will remain at its current low levels in the region therefore remains an open question. The exception is Poland, where HIV infection was detected in IDUs in the late 1980s. Currently, there are, on average, between 350 and 600 new infections reported annually.[20] In the Balkans, a pattern similar to that of central and eastern Europe emerges. Injecting populations are found, but HIV prevalence is currently very low, although risk behaviours may be evident. For example, only 1.3 per cent of first requests for treatment in Sofia were HIV-positive in 1997, although 40 per cent reported sharing injecting equipment in the month prior to entering treatment.[7] In the Balkans, only Serbia and Montenegro appear currently to have significant HIV infection among IDUs.

36. A potential for increased HIV infection from drug-injecting also exists in north Africa and the Middle East. Drug injection is already the major cause of AIDS in Bahrain and about half of all infections in the Islamic Republic of Iran. In Egypt, about 10 per cent of HIV infections are attributed to injection.[17] In general, for Africa as a whole, the evidence suggests increased rates of injecting in the countries of northern Africa bordering the Mediterranean, but not for the rest of the continent. If central and southern Africa are considered, drug injection appears uncommon, and HIV infection is predominantly associated with sexual behaviour. For example, in South Africa, very little injecting of any drug is reported by those seeking treatment (0 to 3 per cent, depending on site).[7] Similarly, a 1998 rapid assessment exercise in Nigeria found that 10 per cent of street contacts (non-random sample of drug consumers) reported injecting heroin.[21] The data would suggest that drug injection is uncommon, but not unknown, in central and southern Africa. However, for many countries, data on patterns and trends in drug consumption are virtually absent. Again, that highlights a need for improved monitoring systems throughout the African continent.

37. In China, although HIV rates currently remain relatively low in population terms, the number of individuals affected is considerable (just under half a million infected individuals), and the majority of new infections are among drug injectors.[17] Drug injection itself appears to be increasing and spreading to areas where it was previously unreported. The potential for increased infections therefore seems considerable. Drug injecting has also been increasing in Myanmar and spreading from urban to rural areas. Prevalence estimates are worryingly high[22] and estimates from surveillance work found between 22 and 84 per cent of IDUs tested were HIV-positive (1998).[23] Studies in Kachin State and the Northern Shan State produced HIV prevalence rates of 93 and 82 per cent, respectively.[22]

38. Heroin injection appears to be increasingly popular in Viet Nam,[8] may have recently begun in the Lao People's Democratic Republic, and has been established for some time in Hong Kong Special Administrative Region (SAR) of China and Thailand.[22] In Malaysia, it was estimated that, in 1995, 77 per cent of HIV cases were among IDUs.[24] As of June 1997, the cumulative total of known HIV-infected persons was 21,863, of whom 76 per cent were identified as IDUs.[22] In India, intravenous drug abuse is becoming more common among opiate addicts. HIV prevalence among IDUs was estimated at 27 per cent[8] in 1997. Reports have also recently emerged of buprenorphine injection in Bangladesh accompanied by high rates of equipment-sharing.[24]

39. As in the case of the Baltic States and the States of the Commonwealth of Independent States, the difficulties in accurately estimating the prevalence of drug abuse suggests that individual estimates should be treated with caution, and that there is a pressing need for an improved information base. The picture is also similar in the sense that some countries already have significant HIV infection, while in others, to a greater or lesser extent, the conditions for increased infection exist, but rates currently remain low. Individual estimates of both injecting prevalence and HIV infection are clearly open to question. However, sufficient evidence exists to suggest that drug-related HIV

infection poses, and will continue to pose, a serious problem for many countries in central Asia.

40. Because of the need for brevity and the scarcity of data, the foregoing review of the global problem of drug injection and HIV infection is not comprehensive. It illustrates, however, that drug-related HIV infection remains one of the critical global issues. The situation has stabilized to some extent in developed countries. There is a danger that the problems faced in developing countries may become overlooked. The problems are made worse by the absence of reliable data sources. Drug-injecting has spread to many areas in which it was previously uncommon or unknown. High rates of risk behaviour known to be associated with HIV transmission are also commonly found among the new injecting populations.

B. Hepatitis C

41. HIV infection is not the only blood-borne virus to be associated with drug injection. Other concerns exist about the transmission of hepatitis B, hepatitis C and tuberculosis. As regards tuberculosis and drug-resistant tuberculosis in particular, the knowledge base is so poor that it does not permit informed comment. It is a source of concern, however, that infections appear to be increasing in the Baltic States and in the States of the Commonwealth of Independent States.[25]

42. Hepatitis C infection is increasingly causing concern in many countries. Unlike HIV, drug injection is the major mode of transmission for hepatitis C, as sexual transmission appears rare. There are a number of reasons for the increased worries about hepatitis C infection rates.[26] The prevalence of hepatitis C among drug injectors is usually high, even where HIV rates remain low. There is little evidence to suggest that interventions that have arguably proved effective in reducing HIV transmission inhibit the transmission of hepatitis C. Unlike hepatitis B, no immunization option currently exists. Drug injectors often have other problems, such as alcohol dependance, that are associated with the poor outlook in cases of hepatitis C infection.

43. In countries in which HIV infection rates are currently low, given the high prevalence of hepatitis C infection in IDU populations, the long-term consequences in terms of morbidity and mortality are likely to be greater that for HIV. Current prevalence estimates vary, but are usually high. For example, hepatitis C remains the most frequent notifiable infection in Australia (1998),[13] and prevalence rates are estimated at around 50 per cent. In Europe,[6] rates for hepatitis C infection are higher and more uniform than for hepatitis B among IDUs. Only Belgium and Luxembourg report prevalence figures at under 50 per cent (47 and 18 per cent), and most countries report rates of between 60 and 80 per cent; Sweden reported the highest rate in the European Union in 1998 (92 per cent). In the United States, overall hepatitis C prevalence is estimated at 77 per cent among IDUs who had been injecting for six years or more[18] (for purposes of comparison, hepatitis B and HIV were estimated at 66 and 20.5 per cent, respectively, for this group). High rates of hepatitis C have also been reported in Japan.[22] However, in general, for drug injectors in many countries of the world, information on hepatitis C infection rates and trends remains poor or simply unavailable.

C. Drug overdoses and mortality

44. Concern about drug overdoses has in recent years become more apparent in a number of countries. Arguably, the topic had previously been somewhat overlooked, since research agendas have focused on questions relating to HIV transmission. Drug overdoses are not restricted to injecting populations, but for some drug types at least, they are more strongly associated with injecting than with other modes of administration. Renewed interest in the topic has centred on Australia, the United States and the European Union.

45. It is important to note that for many countries with low HIV rates among drug abusers, drug overdoses have consistently been the largest cause of mortality among that group. Data on drug-related death is notoriously difficult to standardize and analyse, and for many countries, there is no understanding of the long-term mortality rates associated with different patterns of drug abuse.

46. Injecting of opiates appears particularly associated with drug overdoses. Patterns of drug mortality also vary across time. For example, in the European Union, drug-related deaths increased markedly during the late 1980s and early 1990s, and since then has stabilized or declined in most countries (with the exception of Greece, Ireland and Portugal).[6] In 1998, 737 Australians died from opiate overdoses, a 23 per cent increase on the 1997 figures.[27] The importance of opiate overdoses is reflected in the

observation that opiate overdoses account for almost 9 per cent of all deaths in the 15-44 age group in Australia.

47. Drug overdoses remains an important but poorly understood phenomenon. Only in a few countries do sufficient data exist to begin to understand the factors associated with deaths resulting from drug overdoses or support the development of appropriate responses. In developing countries, virtually nothing is known about the long-term mortality rates of drug users or the factors that influence the taking of overdoses.

V. Data collection

48. A recurring theme in the present report has been the lack of good data to enable a comprehensive understanding of global trends in the abuse of illicit substances. But the lack of data is not universal. Investment in data collection systems combined with methodological advances now mean that for some regions of the world, dramatic improvements are observable in the quality and quantity of available information. For the most part, the improvements have occurred in developed countries. Given that some of the most disturbing trends in drug abuse are now occurring in developing countries, there exists a critical need to invest in enhancing the capacity of developing countries to monitor the drug abuse situation. UNDCP, through the global programme on assessing the magnitude of drug abuse, will assist countries in developing their data collection capacity. Even where data exist, comparability between countries and regions remains poor. To develop a clear understanding of the global drug abuse problem, there is a need to develop and use more comparable and standardized indicators. UNDCP is actively working with relevant organizations, at the international, regional and national level, to agree on common definitions and measures for describing patterns and trends in drug abuse. It is hoped that agreement on a common global data set has become, for the first time, a realistic possibility.

Notes

[1] *Official Records of the Economic and Social Council, 1997, Supplement No. 8* (E/1997/28/Rev.1 and E/CN.7/1997/12/Rev.1), part one, para. 80 (a).

[2] South African Community Epidemiology Network on Drug Use, "Monitoring alcohol and drug abuse trends in South Africa (July 1996-December 1998)", *Research Brief*, vol. 2, No. 1, 1998.

[3] UNDCP, *The Drug Nexus in Africa* (Vienna, March 1999).

[4] National Institute on Drug Abuse, "Drug trends in the United States and NIDA activities", paper presented to the Council of Europe/Pompidou Group twenty-ninth meeting of epidemiological experts in drug problems, held in Strasbourg on 7 and 8 June 1999.

[5] Community Epidemiology Work Group, "Epidemiologic trends in drug abuse" (Rockville, Maryland, 1998).

[6] European Monitoring Centre for Drugs and Drug Addiction, *Extended Annual Report on the State of the Drugs Problem in the European Union* (Lisbon, 1999).

[7] "Treated drug users in 23 European cities: data 1997, trends 1996-97", final report of the Pompidou Group project on treatment demand (Strasbourg, Council of Europe, 1999).

[8] "Report of the Asian Multicity Epidemiology Work Group", Centre for Drug Research International Monograph Series (Penang, Universiti Sains Malaysia, December 1998).

[9] National Institute on Drug Abuse, *Monitoring the Future* (Bethesda, Maryland, 1999), and news release (17 December 1999).

[10] Shane Darke and others, "Illicit drug use in Australia: epidemiology, use patterns and associated harm" (Sydney, National Drug and Alcohol Research Centre, University of New South Wales, 1999).

[11] UNDCP Regional Centre for East Asia and the Pacific, "Regional drug abuse update--July 1999" (Bangkok, 1999).

[12] Malcom Ramsay and Sarah Partridge, *Drug Misuse Declared in 1998: Results from the British Crime Survey*, Home Office Research Study 197 (London, Her Majesty's Stationery Office, 1999).

[13] National Centre in HIV Epidemiology and Clinical Research, *Annual Surveillance Report* (Darlinghurst, New South Wales, 1999).

[14] Gerry Stimson, Don C. Des Jarlais and Andrew Ball, *Drug Injecting and HIV Infection* (World Health Organization, 1998).

[15] United Nations International Drug Control Programme, *Global Illicit Drug Trends* (New York, 1999).

[16] National Institute on Drug Abuse, "Report on the inaugural meeting of the Global Research Network on HIV Prevention in Drug-Using Populations" (Bethesda, Maryland, 1998).

[17] Joint United Nations Programme on Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome (UNAIDS) and World Health Organization, "AIDS epidemic update" (December 1999).

[18] National Institute on Drug Abuse, "25 years of discovery to advance the health of the public" (Bethesda, Maryland, 1999).

[19] Bureau of HIV/AIDS, STD and TB, "HIV/AIDS Epi Updates" (Ottawa, 1998).

[20] K. Dehne, "The HIV epidemic in central and eastern Europe: update", report prepared for UNAIDS (August 1999).

[21] Centre for African Settlement Studies and Development, "The drugs nexus in Africa: Nigeria", study prepared for UNDCP (Ibadan, Nigeria, 1998).

[22] Asian Harm Reduction Network, "The hidden epidemic: a situation assessment of drug use in south-east and east Asia in the context of HIV vulnerability" (Bangkok, 1998).

[23] Department of Health of Myanmar, AIDS prevention and control project, "Sentinel surveillance data for March 1998".

[24] "Exploratory studies on drug abuse in the Asian region", Centre for Drug Research International Monograph Series (Penang, Universiti Sains Malaysia, 1997).

[25] European Centre for the Epidemiological Monitoring of AIDS, "Surveillance of tuberculosis in Europe: report on tuberculosis cases notified in 1997" (Saint-Maurice, France, 1997).

[26] N. Crofts and others, "Epidemiology of hepatitis C virus infection among injecting drug users in Australia", *Journal of Epidemiology and Community Health*, vol. 51:0 (1997).

[27] National Drug and Alcohol Research Centre, press release (Sydney, Australia, 7 December 1999).

Annex

Data on trends in drug abuse and country reporting

Table 1
Data on trends in the abuse of heroin
(Number of countries reporting: 48)

Trends	*Regional and country reporting in 1998*[a]
Increase in abuse	
Total number of countries reporting: 31 Percentage of 1998 reports: 64	Africa (6): Ghana, Libyan Arab Jamahiriya, Mauritius, Morocco, United Republic of Tanzania, Zimbabwe Near and Middle East (3): Jordan, Kuwait, Syrian Arab Republic Americas (3): Canada, Colombia, Mexico Asia (11): China, India, Indonesia, Kyrgyzstan, Malaysia, Philippines, Republic of Korea, Singapore, Sri Lanka, Tajikistan, Uzbekistan Europe (8): Austria, Belarus, Bulgaria, Ireland, Norway, Russian Federation, the former Yugoslav Republic of Macedonia, United Kingdom of Great Britain and Northern Ireland
Stable level of abuse	
Total number of countries reporting: 7 Percentage of 1998 reports: 15	America (2): Panama, Suriname Near and Middle East (1): Bahrain Europe (4): Hungary, Luxembourg, Portugal, Sweden
Decrease in abuse	
Total number of countries reporting: 9 Percentage of 1998 reports: 21	Asia (4): Brunei Darussalam, China (Hong Kong SAR), Myanmar, Thailand Europe (5): Czech Republic, France, Liechtenstein, Spain, Switzerland

Source: Annual reports questionnaire.

[a] Number of countries reporting indicated in parentheses.

Table 2

Data on trends in the abuse of amphetamine-type stimulants

(Number of countries reporting: 45)

Trends	*Regional and country reporting in 1998*[a]
Increase in abuse	
Total number of countries reporting: 30 Percentage of 1998 reports: 67	Africa (1): Cameroon Americas (5): Bolivia,[b] Brazil, Colombia, Guatemala, Mexico Asia (7): Brunei Darussalam, China (Hong Kong SAR), Indonesia, Malaysia, Republic of Korea, Singapore,[c] Thailand Near and Middle East (1): Kuwait Europe (15): Bulgaria, Czech Republic, Finland, France, Germany, Hungary, Luxembourg, Malta, Norway, Portugal,[d] Republic of Moldova, Sweden, Switzerland, the former Yugoslav Republic of Macedonia, United Kingdom of Great Britain and Northern Ireland[e] Oceania (1): New Zealand
Stable level of abuse	
Total number of countries reporting: 10 Percentage of 1998 reports: 22	Africa (2): Ghana, Zimbabwe Americas (4): Canada, Ecuador, Panama, United States of America Asia (1): Uzbekistan Europe (3): Austria, Belarus,[f] Spain
Decrease in abuse	
Total number of countries reporting: 5 Percentage of 1998 reports: 11	Asia (3): China (Macao SAR), Japan, Philippines Europe (2): Ireland,[g] Russian Federation[f]

Source: Annual reports questionnaire.

Notes: Caution should be exercised in interpreting this table, as countries report trends in respect of a number of drugs classified as amphetamine-type stimulants (including methamphetamine, the Ecstacy group and amphetamine). Because of deficiencies in the current reporting system, it is not always possible to identify the individual drug type.

Table based on summary of replies. Where possible, trends relating to specific drug types are indicated.

[a] Number of countries reporting indicated in parentheses.

[b] Methamphetamine stable.

[c] MDMA decrease.

[d] Amphetamine decrease.

[e] Methamphetamine decrease.

[f] MDMA stable.

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Table 3

Data on trends in the abuse of cocaine

(Number of countries reporting: 52)

Trends	*Regional and country reporting in 1998*[a]
Increase in abuse	
Total number of countries reporting: 34 Percentage of 1998 reports: 64	Africa (5): Cameroon, Ghana, Morocco, United Republic of Tanzania, Zimbabwe Near and Middle East (2): Jordan, Lebanon Americas (10): Bolivia, Brazil, Canada, Chile, Costa Rica, Ecuador, Guatemala, Mexico, Nicaragua, Suriname Asia (3): China (Hong Kong SAR), Republic of Korea, Uzbekistan Europe (14): Austria, Bulgaria, France, Germany, Hungary, Ireland, Liechtenstein, Malta, Norway, Russian Federation, Spain, Sweden, the former Yugoslav Republic of Macedonia, United Kingdom of Great Britain and Northern Ireland
Stable level of abuse	
Total number of countries reporting: 13 Percentage of 1998 reports: 15	Americas (4): Colombia, Costa Rica, Grenada, Panama Asia (2): Japan, Thailand Near and Middle East (2): Kuwait, Syrian Arab Republic Europe (4): Belarus, Czech Republic, Luxembourg, Switzerland Oceania (1): New Zealand
Decrease in abuse	
Total number of countries reporting: 4 Percentage of 1998 reports: 8	Americas (2): Bahamas, United States of America Asia (2): China (Macao SAR), Philippines

Source: Annual reports questionnaire.

[a] Number of countries reporting indicated in parentheses.

Table 4

Data on trends in the abuse of cannabis

(Number of countries reporting: 64)

Trends	*Regional and country reporting in 1998*[a]
Increase in abuse	
Total number of countries reporting: 38 Percentage of 1998 reports: 59	Africa (6): Cameroon, Ghana, Libyan Arab Jamahiriya, Mauritius, Morocco, Zimbabwe Americas (10): Bahamas, Bolivia, Brazil, Chile, Colombia, Costa Rica, Ecuador, Nicaragua, Suriname, United States of America Asia (6): China (Hong Kong SAR), Indonesia, Japan, Kazakhstan, Republic of Korea, Myanmar Near and Middle East (1): Kuwait Europe (15): Austria, Belarus, Bulgaria, Czech Republic, Finland, France, Germany, Hungary, Liechtenstein, Norway, Republic of Moldova, Spain, Sweden, Switzerland, the former Yugoslav Republic of Macedonia
Stable level of abuse	
Total number of countries reporting: 16 Percentage of 1998 reports: 25	Africa (2): Namibia, United Republic of Tanzania Americas (5): Canada, Grenada, Guatemala, Mexico, Panama Asia (3): Brunei Darussalam, Sri Lanka, Uzbekistan Europe (5): Ireland, Malta, Portugal, Russian Federation, United Kingdom of Great Britain and Northern Ireland Oceania (1): New Zealand
Decrease in abuse	
Total number of countries reporting: 10 Percentage of 1998 reports: 16	Asia (8): China (Macao SAR), India, Kyrgyzstan, Malaysia, Philippines, Singapore, Tajikistan, Thailand Near and Middle East (2): Lebanon, Syrian Arab Republic

Source: Annual reports questionnaire.

[a] Number of countries reporting indicated in parentheses.

Table 5

Countries and territories reporting injecting drug use and drug-related HIV infection

Countries and territories

Africa

Benin[b]
Cameroon[b]
Chad
Côte d'Ivoire
Egypt
Ethiopia
Gabon
Ghana[b, d]
Kenya
Libyan Arab Jamahiriya[b]
Mauritius
Morocco[d]
Nigeria[d]
Senegal
South Africa
Sudan
Tunisia
Uganda
United Republic of Tanzania[d]
Zambia
Zimbabwe[b]

Americas[a]

Argentina
Bahamas
Bermuda[c]
Bolivia[c]
Brazil
Canada
Chile
Colombia
Costa Rica
Dominican Republic
Ecuador
El Salvador
Guatemala[c]
Haiti[c]
Honduras
Jamaica[c]
Mexico
Nicaragua
Panama
Paraguay[c]
Puerto Rico
Suriname[c]
United States of America
Uruguay
Venezuela

Asia[a]

Azerbaijan[c]
Bahrain
Bangladesh[c]
Brunei Darussalam[b]
Cambodia[b]
China
Hong Kong SAR of China
Macao SAR of China[c]
Taiwan Province of China[c]
Cyprus
India
Indonesia
Iran (Islamic Republic of)[f]
Iraq[c]
Israel
Japan
Jordan
Kazakhstan
Kuwait[b]
Kyrgyzstan[c]
Lao People's Democratic Republic[c]
Malaysia
Myanmar
Nepal[c]
Oman
Pakistan[c]
Philippines
Qatar
Republic of Korea
Saudi Arabia
Singapore
Sri Lanka
Syrian Arab Republic
Tajikistan[a]
Thailand
Turkmenistan[c]
Viet Nam
United Arab Emirates[c]
Uzbekistan

Europe[a]

Albania[c]
Austria
Belarus
Belgium
Bosnia and Herzegovina[b]
Bulgaria[c]
Croatia
Czech Republic
Denmark
Estonia[c]
Finland
France
Georgia[b]
Germany
Greece
Hungary
Iceland
Ireland
Italy
Latvia
Liechtenstein
Lithuania
Luxembourg
Malta
Monaco
Netherlands
Norway
Poland
Portugal
Republic of Moldova
Romania
Russian Federation
San Marino
Slovakia
Slovenia
Spain
Sweden
Switzerland
the former Yugoslav Republic of Macedonia[c]
Turkey
Ukraine
United Kingdom of Great Britain and Northern Ireland
Yugoslavia

Oceania[a]

Australia
Fiji[c]
French Polynesia[b]
Guam[c]
Micronesia (Federated States of)
Nauru[b, c]
New Caledonia[c]
New Zealand

Number of countries reporting by region and territories

Africa	21
Americas	25
Asia	38
Europe	44
Oceania	8
Total	136

Sources: Annual reports questionnaire, part II, drug abuse; Gerry Stimson, Don C. Des Jarlais and Andrew Ball, *Drug Injecting and HIV Infection* (World Health Organization, 1998); UNAIDS/WHO fact sheet; and Pompidou Group project on treatment demand, final report on treated drug users in 23 European cities.

[a] Except where otherwise indicated, all countries and territories reported HIV infection in IDUs.
[b] New reporting country or territory.
[c] No HIV infection in IDUs reported.
[d] HIV infection in IDUs reported.